

1970

The Role of the Health Aide in a Reservation Program

Peter Hackett
Bemidji State College

Follow this and additional works at: <https://digitalcommons.morris.umn.edu/jmas>



Part of the [Sociology Commons](#)

Recommended Citation

Hackett, P. (1970). The Role of the Health Aide in a Reservation Program. *Journal of the Minnesota Academy of Science*, Vol. 37 No. 1, 46-49.

Retrieved from <https://digitalcommons.morris.umn.edu/jmas/vol37/iss1/14>

This Article is brought to you for free and open access by the Journals at University of Minnesota Morris Digital Well. It has been accepted for inclusion in Journal of the Minnesota Academy of Science by an authorized editor of University of Minnesota Morris Digital Well. For more information, please contact skulann@morris.umn.edu.

The Role of the Health Aide in a Reservation Program

PETER HACKETT*

ABSTRACT — This study of the training and use of health aides in an Indian reservation community program suggests that the success of such a program depends on certain characteristics of both the community and the program. Comparison of this program with sociological studies of other community health programs which failed suggests that the definition of "community" must be confined to the group beset with pressing health problems that cannot be met without assistance from the larger community. Participation in conducting the program by representatives of the recipient community also appears essential to success.

The community studied is a closed Indian reservation in the north-central part of the United States. The area is heavily forested and isolated from large population centers. There are three small towns on the reservation, but most commerce and services are centered in one of them. The latest available census reported 3,400 residents on the reservation.

The reservation economy is based primarily on utilization of timber owned and managed by the Indians themselves. It is enhanced by a large saw-mill, a fishery, and the leasing out of recreational facilities.

The principal reservation government is an 11-member Tribal Council elected to office for four-year terms. The Tribal Council acts as a legislative body and operates under a constitution and by-laws approved by the Secretary of the Interior. The Superintendent of the reservation is appointed by the Secretary of the Interior and the Commissioner of Indian Affairs and, together with the Tribal Council, is responsible for day-to-day administration of the reservation.

A reservation community action program had been in operation for three years at the time of these observations. A number of measures have been instituted to improve training and economic opportunities for reservation members. The community health program described here is one component of the overall program.

Existing Health Services

At this isolated reservation a 70-mile round trip is necessary to reach the nearest non-reservation city, which has the nearest hospital equipped and staffed to do major surgery.

Health services on the reservation are maintained by the United States Public Health Service, Division of Indian Health, and there is a recently-constructed 20-bed in-patient hospital. Laboratory facilities, examination rooms, and dental offices are located in an old two-story

frame building adjoining the new hospital. There is also a one-story frame building in one of the other reservation communities in which an outpatient clinic is provided once a week. The hospital staff includes three physicians, three registered nurses, one dentist, and other paramedical personnel. Staff changes in these facilities are frequent. Physicians serve a two year term (usually in lieu of military service), and there are no senior or resident physicians.

Health problems in this reservation community are similar to those reported from other Indian reservations. Poor communication between the frequently-changed health service personnel and residents results in poor practices related to hygiene, carrying out recommended medical regimes, and seeking medical assistance.

These problems reflect not only the transitory nature of professional services referred to previously but also cultural attitudes in the perception and acceptance of health-related communication. Such cultural blocks to communication have been studied by sociologists from the University of Colorado in the New Mexico Rural Health Survey of 1961. (Hanson, 1961)

The request to the Office of Economic Opportunity for a community health program identified the reservation health problems as follows:

"An Indian on the reservation has one chance in three of living past the age of 65; his white neighbor has two chances in three.

"The probability of an Indian child's death during the first year of life is nearly twice that of a non-Indian child.

"Fifteen children await plastic surgery for the restoration of eardrums destroyed by repeated middle ear infections which had gone untreated too long.

"Trauma, the major source of more than 2,500 emergency room visits to the reservation hospital, often goes untreated until severe complications set in.

"Patients in outlying areas often must wait hours before an ambulance is available to take them to the hospital, because there are often no telephones and no means of public transportation.

"Sixty cases of nephritis were diagnosed among reservation children during the summer of 1966,

* PETER HACKETT received the B.A. degree from Bemidji (Minn.) State College and was later employed as training coordinator in a community health program at an Indian reservation under the Office of Economic Opportunity. The accompanying paper was presented at the annual meeting of the Minnesota Academy of Science in April, 1968.

traceable in all likelihood to streptococci infections, including impetigo, which is widespread.

"There is a high incidence of hepatitis, diabetes, and respiratory ailments."

Community Aides Program

Although many provisions were made for extending and improving medical services on the reservation, the greatest change in the concept of community health grew out of the Health Aides Program.

The requirement that health aides be selected from the reservation population itself created a new approach to community health problems and one which attacked head-on the communication problems and cultural barriers in previous programs.

Sociologists are committed to the view that certain essential elements must be involved for the recognition and effective solution of any community problem. As formulated by Robert K. Merton, these elements are: 1) A perceived discrepancy between some existing (or future) external situation and the values or goals of an individual or organization; 2) A feeling of a need for adaptive activity or for corrective action of some sort; 3) A "puzzle element"—an awareness of ignorance or doubt about at least some of the facts and relationships believed to be relevant to a decision about what, if anything, should be done. (Merton, 1964:18-21)

In discussing planned change in health organizations, Ray H. Elling presented the following considerations: "An invitation for the social scientist to design a new form of organization is highly desirable. At the very least, the groups warranting change must then accept and take part in it. Similarly, while colleagues, professionals, and policy makers are involved in any planned change, groups may also be involved in early phases of change. In any case, the clients must be involved ultimately since they have to accept the product if the effort is to succeed." (Elling, 1966:294)

Earl L. Koos put the matter somewhat more pointedly when he stated: "In the last analysis, the health of the community is based upon the ideas, ideals, attitudes and behavior patterns of the individual and his family, for these determine what he will or will not, can or cannot, expect or accept from those who make health their professional concern." (Koos, 1954, as cited in Deuschle, 1961:45)

Two conclusions seem warranted by a study of the organization of this community health program: 1) Community awareness of the problem and an acute desire to do something about it existed. Merton's conditions appear to have been met. 2) The Office of Economic Opportunity requirement for sub-professional participants from among the recipient group appears to be in line with sociological insights into sound community health programs.

Selection and Training of Aides

In addition to the OEO policy requiring that health aides be selected from among the reservation Indians, it was stipulated that no relatives of tribal officials or professional employees were to be accepted as aides.

A program for training health aides had been developed at the University of California, and trained health aides had been used on an Indian reservation in Arizona, as described by Alice M. Heath, M.P.H.:

"Health aides have been used since 1961 in California health departments, especially during the peak harvest seasons.

"Health education aides were introduced into the Navajo Reservation at Window Rock, Arizona, under a program developed by the University of California School of Public Health for the Division of Indian Health. These aides were thought of as family health educators or hogan-level health educators.

"The Department of National Health and Welfare of Canada has developed a community health worker program for the Indians and Eskimos living north of the 60th parallel. Since 1958 the health educator has been recognized as one of the soundest approaches to training native people as assistants to field staff. The natives had cherished the idea.

"Community health aides were first introduced into California in July, 1961, in Kern County. The agency was engaged in extensive health education programs among Spanish-speaking and other seasonal farm workers and their families. This project focused on the use of community health education aides selected from the farm labor group, hired and paid to learn basic principles of health and hygiene and to assist in the process of health education of their community." (Heath, 1967)

Drawing on the background of the above-described programs for the reservation, it was decided to recruit ten Community Health Aides and ten Family Health Aides in the program. The community aides were to serve as interpreters of health programs and to function in the field of community education. They were selected from among the more articulate members of the group. The family health aides concentrated on individual family groups and assisted families in such areas as diet, food preparation, maternal and child care, and following instructions of doctors and public health nurses.

Both groups of health aides provided transportation for families to medical facilities and other welfare service agencies. The aides thus developed a liaison service between established health and welfare personnel and their clients.

Applicants for the health aide positions provided detailed educational and social histories as the basis for initial selection. Next, educational records and school personnel were consulted. Finally, the Davis Reading Test was administered to measure both reading speed and comprehension at the 11th grade level.

In line with OEO policy selection from among the reservation residents, and based on known characteristics of the population, the following additional criteria were employed: number in family, family income to determine need and eligibility, educational level, previous work experience, interest in the health program itself, knowledge of the local Indian language, availability of a car.

The two categories of aides and respective type of duties they would be required to perform were also taken

into consideration. The more outgoing individuals who seemed to have fewer problems communicating with others were slated for training as community health aides for the counseling and educational role.

Selection of recommended applicants was made after the Project Director conferred with other health program personnel, and the list of selectees was then submitted to the Tribal Council for final and formal approval.

Personal characteristics of the twenty health aides, all women, are of interest. The age range from 23 to 45. Fifteen married, one widowed, four single. Fourteen of these women had children, seven had four children each; two had five children each, two had seven children each, two had two children each, and one had three children. Education of the aides ranged from the 7th grade through high school.

Training of the aides started with a three-week orientation program on the reservation. This covered existing health services on the reservation and in communities of the area; role of the community health worker; orientation to family planning; and the American Red Cross Standard First Aid Course. A mental hygiene unit also was included, dealing with rehabilitation resources, problems of mental illness, and alcoholism. Family nutrition and food buying constituted the subject matter of the third week of orientation.

Additional training was provided at a private liberal arts college 200 miles from the reservation where a recently developed nursing program was available.

Community health aide trainees received eight weeks of initial instruction, and the family health aide trainees received six weeks of instruction.

Training for both groups included germ theory, human anatomy, maternal and child care, the Red Cross Home Nursing Course, nutrition, and the First Aid Course.

In addition, the community health aides were trained in consumer practices and the use of audio-visual aids.

Since most of the health aide trainees had families and had lived most of their lives in the insulated environment of the reservation, the training experience provided a great challenge to them. Evaluations by instructors at the college attested to the success of the program. All but three of the trainees were rated outstanding in their course work, and these three did average good work.

In comparing the quality of this health aide program with others, reference is made to comments of Alice M. Heath in the article previously cited.

"At least 200 hours (20 hours per week for ten weeks) must go into the training before the aide can function relatively independently on the job." (Heath, 1967) Family health aide trainees in this program received a total of 240 hours of training, while community health aide trainees received a total of 320 hours of training.

In the two-month period following training, the aides made 1,104 home visits. As a result, clinic attendance increased by more than 25 percent and contacts with Public Health Service personnel increased appreciably. Increased transportation facilities, including an ambulance and two-way radio communication provided

through another component of the total health program, also increased utilization of health facilities.

The new health aides kept detailed records of contacts with families, including the responses of family members to health information. A great deal more understanding of health practices developed than even the most optimistic proponent of the program could have predicted, and greater acceptance of inconveniences was evident.

Evaluation of Program and Community

In evaluating the effectiveness of this community health effort, the sociologist must take into consideration the type of community as well as features of the program.

The Office of Economic Opportunity during 1966 and 1967 set up 40 additional community health programs, mostly in urban neighborhoods. These urban programs were similar to the one described here, but the Indian reservation community of this study was perhaps more extreme in its isolation.

The fact that community characteristics of cultural insulation, isolation and poverty are relevant to the success of the program is attested to by the study of the death of community health councils throughout the country during the 1950s (Sower, Holland, Tiedke, and Freeman). These authors found that most large American communities have many voluntary organizations but none with power or authority to assume responsibility for the health needs of the entire community. The social characteristics of visible deprivation within a homogeneous group, as distinguished from the larger heterogeneous community, seems necessary to the success of a community health program.

The participation of the recipient group in carrying out the health aide program was a strength in the total program. Nevertheless, certain problems were encountered and must be examined. These problems relate to the sociology of community action as well. The established professional workers in existing health and welfare agencies on the reservation represent some of the characteristics of the power structure in any community. Their roles are validated by their professional standing and by their affiliation with long-established community agencies. There is, therefore, a built-in antipathy between this approach to community health and welfare problems and the newer, less professionalized, less structured, grass roots approach represented by the new community health program and the sub-professional health aides. On a more concrete level, the new health aides were hearing complaints and opinions of clients and patients which had never been voiced before. The liaison role became, in fact, a two-way relationship. Feed-back from a presumed inarticulate clientele appeared.

While problems arose and any realistic appraisal of the community health program must take them into account, they did not either threaten or diminish the effort as a whole. In spite of new roles and in some cases strained relationships, the program remains viable and strong.

Acknowledgments

The advice and direction of Edward D. Stokes, assistant professor of sociology at Bemidji State College, in this research and preparation of the paper is gratefully acknowledged.

References

- ELLING, RAY H. The Design and Evaluation of Planned Change in Health Organizations. In Shostak, A., Editor. *Sociology in Action*. Homewood, Ill., The Dorsey Press, 1966, pp. 292-302.
- HANSON, ROBERT C. *New Mexico Rural Health Survey*. February, 1961. University of Colorado. Unpublished project report.

KOOS, EARL L. The Health of Regionville, 1954, Columbia University Press, as cited in Kurt W. Deuschle, "Organizing Preventive Health Programs to Meet Health Needs," *The Annals* vol. 337 (September, 1961) p. 45.

MERTON, ROBERT K. and EDWARD C. DEVEREUX. Practical Problems and the Uses of Social Science. *Transaction* vol. 1 (July, 1964), pp. 18-21.

SOWER, CHRISTOPHER, et al. The Death of the Health Council, 1957. In Warren, R., Editor. *Perspectives on the American Community*. Chicago, Ill. Rand McNally, 1966, pp. 280-291.

Divorce Practices Among Some North American Indian Tribes

GEORGE E. DICKINSON*

The objective of this study is to present an overview of marriage termination practices among North American Indians and to compare the practices of these early inhabitants of the continent with contemporary practices. The Human Relations Area File was utilized to gather information on marriage termination practices of North American Indian tribes. Divorce was the most common practice used by the Indians; and divorce grounds available to them proved to be similar to contemporary North American customs. The consequences of divorce varied with different Indian tribes, but all tribes studied had similar attitudes toward caring for children of divorced parents.

North American inhabitants have a history of divorce which is very similar among both Indian and non-Indian populations. While the procedures of divorce differ, the grounds for divorce remain basically similar. Bohannon (1963) states that anthropologists have failed to study patterns of marriage termination in various cultures; thus this research will relate the various grounds for divorce as well as the consequences of divorce among these early inhabitants of North America and contemporary dwellers on this continent.

Theoretical framework of the study

Despite the fact that social systems are not designed according to a blueprint, they are nevertheless organized (Loomis, 1960). There are accepted ways for earning a living, distributing rights and privileges, assimilating new members into groups, holding competition and conflict at a minimum, and establishing means whereby order is developed and maintained. In spite of the fact that individual differences occur between members of a social system, people are able to cooperate in carrying out transactions and to carry on in a somewhat orderly manner.

This "miracle of social organization" is due to the elements and processes which comprise the system. The elements tend to constitute the social structure of the system; whereas the processes fuse, support, and change the relations between the elements through time (Loomis, 1960).

Marriage, which is sometimes followed by termination through means other than death, is an element in this social organization. The various social systems devise ways which are acceptable for terminating marriage. According to Merton and Nisbet (1960):

All marriage systems require that at least two people, with their individual desires, needs, and values, live together, and all systems create some tensions and unhappiness. In this basic sense, then, marriage "causes" divorce, annulment, separation, or desertion. But though a social pattern must be able to survive even when many individuals in it are unsatisfied, it also will contain various mechanisms for keeping interpersonal hostilities within certain limits. Some family systems prevent the development of severe marital strains, but offer few solutions if they do develop. Two main patterns of prevention are discernible. One is to lower the satisfactions that the individual may expect from marriage; and the second is to value the kinship network more than the relation between husband and wife.

* GEORGE E. DICKINSON is an assistant professor in the Department of Sociology and Anthropology at Gustavus Adolphus College, St. Peter, Minnesota. He received the Ph.D. degree from Louisiana State university in 1969 and holds master's and bachelor degree from Baylor University.